

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) ERLING ALBERT ANDERSEN						2a. DATE OF DEATH Month 19 Day 19 Year 1969			2b. HOUR 8:30 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 1, 1897		6. AGE (In years lost birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Norway		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.					
10. CITY OR TOWN OF DEATH Joppa			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 404 Avery Court			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dockbuilder			12b. KIND OF BUSINESS OR INDUSTRY construction		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 404 Avery Court		
14. FATHER'S NAME First Ole Middle Edward Last Andersen				15. MOTHER'S MAIDEN NAME First Amelia Middle -- Last Rasmussen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 097-09-3446-A		17. INFORMANT Address Joppa, Md. Mrs. Mary H. Andersen, 404 Avery Court					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral artery thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) carcinoma of the kidney											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (his hospital) attended the deceased from Oct , 19 68 , to March 19 19 69 , that (I) (we) last saw the deceased alive on March 19 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Emory J. Linder						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Mar. 20, 1969			
22d. PHYSICIAN'S NAME (Type) Emory J. Linder						22e. ADDRESS 902 Averill Road, Joppa, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 22, 1969		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Joppa Harford Md.					
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.						25a. REC'D BY REGISTRAR MAR 24 1969		25b. REGISTRAR'S SIGNATURE William J. ...			

DATE: 10/10/1971 TIME: 10:00 AM

TO: DIRECTOR, FBI (100-442100) FROM: SAC, NEW YORK (100-100000)

SUBJECT: JAMES EARL RAY; AKA; FUGITIVE; MURDER OF MARTIN LUTHER KING, JR.

RE: NEW YORK TELETYPE TO BUREAU, OCTOBER NINE, LAST.

ADVISE THAT THE FOLLOWING INDIVIDUALS WERE INTERVIEWED:

1. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

2. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

3. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

4. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

5. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

6. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

7. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

8. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

9. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

10. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

11. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

12. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

13. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

14. JAMES EARL RAY, AKA, FUGITIVE, MURDER OF MARTIN LUTHER KING, JR.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03924

CERTIFICATE OF DEATH

03917

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Whiteford		c. LENGTH OF STAY IN 1b 2 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS Chestnut St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELSWORTH Middle WILSON Last ATKIN			4. DATE OF DEATH Month March Day 19 Year 1969		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1892	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Whiteford, Md.	
13. FATHER'S NAME Robert Atkin			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 186-01-2868		17. INFORMANT Address James E. Atkin, Whiteford, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Cor Pulmonare Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema & Chronic Bronchitis (c) years					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1950 to March 19, 1969 , that (I) (we) last saw the deceased alive on March 16, 1969 , and that death occurred at 8:47 M, from causes and on the date stated above.					
22a. SIGNATURE Josiah A. Hunt		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED March 20, 1969
22c. PHYSICIAN'S NAME (Type) Josiah A. Hunt		M.D.		22d. ADDRESS Delta, Penna.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar. 22, 1969	23c. NAME OF CEMETERY OR CREMATORY Slate Ridge		23d. LOCATION (City or Town) (County) (State) Delta York Pa.	
24. FUNERAL DIRECTOR JOHN H. HARKINS		ADDRESS Delta, Penna.		25a. REC'D BY REGISTRAR DATE MAR 24 1969	25b. REGISTRAR'S SIGNATURE Charles Judge

03824

REPORT

Annual-1961-1962

Department of

Geography and

History

Department of

Geography and

1961-1962

Department of

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FOR STATE
HEALTH DEPT.

03925

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03918

1. DECEASED-NAME (Type or Print) Robert T Ellwood Bailey				2a. DATE KNOWN OF DEATH ESTI- MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 3-12-69				2b. HOUR <input type="checkbox"/> M <input type="checkbox"/> 8P	
3. SEX M		4. RACE W		5. DATE OF BIRTH FEB 21, 1943		6. AGE (In years last birthday) 26 YRS.		7c. DATE PRONOUNCED DEAD March 12 Year 19 Day 12 Hour 8P	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Co.		Md.	
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1017 Rockspring Rd				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Brick Layer		12b. KIND OF BUSINESS OR INDUSTRY MASON	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Harford Bel Air		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER Volte Road	
14. FATHER'S NAME First Willard Middle BARNES Last Bailey				15. MOTHER'S MAIDEN NAME First Margaret Middle Riley Last Riley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16b. SOCIAL SECURITY NO (If yes give war or dates of service) 1964-1966		17. INFORMANT Father - 838-5197		ADDRESS RFD #3, Box #394, Bel Air, Maryland 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) G-S-W Cerebrum 955X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 3-12-69 HOUR 730 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot self with pistol			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 1017 Rockspring Rd.		21f. LOCATION Street or R.F.D. No. Bel Air		City or Town Harford		County Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Gerald C Palmer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 3-12-69			
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 15, 1969		23c. NAME OF CEMETERY OR CREMATORY Centre Meth. Ch. Cem.		23d. LOCATION (City or Town) Forest Hill Harford Co. Md.		(County) (State)	
24. FUNERAL DIRECTOR Joseph William Foster				ADDRESS West Broadway & Williams Street		25a. REC'D BY REGISTRAR MAR 14 1969		25b. REGISTRAR'S SIGNATURE William J. Judge	
City or Town Bel Air, Maryland				State 21014					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03919

1. DECEASED-NAME (Type or print) First Middle Last Hilda Bickham			2a. DATE OF DEATH Month Day Year 3 21 1969		2b. HOUR 1:05 M
3. SEX Female	4. RACE American	5. DATE OF BIRTH 8-15-94		6. AGE (In years last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penna.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford Md.		
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brevin Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford	13c. CITY OR TOWN Havre de Gr.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 351 Wilson St
14. FATHER'S NAME First Middle Last George Jenkie		15. MOTHER'S MAIDEN NAME First Middle Last (Foster Parents) Margaret Jenkie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 61-22-3299-B		17. INFORMANT Step-Daughter Address Anna Mae Robbins, 118 St. John St. Havre de Gr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardiac Decompensation 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, Generalized (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Old and Recent Cerebrovascular Thrombosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1-24, 1969, to 3-21, 1969, that (I) (we) last saw the deceased alive on 2-24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Daute H. Monakic, M.D.		22c. DATE SIGNED 3-21-69		22d. PHYSICIAN'S NAME (Type) DAUTE H. MONAKIC, MD 211 N. Union Ave Havre de Grace	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-23-69		23c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery	
24. FUNERAL DIRECTOR TARRING Funeral Home ABERDEEN, Md.		23d. LOCATION (City or Town) (County) (State) Perryman, (Harford) Maryland		25a. REC'D BY REGISTRAR DATE MAR 24 1969	
25b. REGISTRAR'S SIGNATURE William J. Judge					

3520

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

Page 6

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03927

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03920

1. DECEASED-NAME (Type or print) <i>Emma</i>		First	Middle	Last	2a. DATE OF DEATH Month <i>March</i> Day <i>18</i> Year <i>1969</i>		2b. HOUR <i>3:30</i> PM		
3. SEX <i>Female</i>		4. RACE <i>colored</i>		5. DATE OF BIRTH <i>7/17/1915</i>		6. AGE (In years last birthday) <i>53</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>PA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i>			Md.
10. CITY OR TOWN OF DEATH <i>HAURE de GRACE</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD Memorial Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSE-KEEPER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>CECIL</i>		13c. CITY OR TOWN <i>Rising Sun</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <i>DAVID</i> Middle <i>BOND</i> Last <i>HELEN</i>		15. MOTHER'S MAIDEN NAME First <i>HELEN</i> Middle <i>TALOR</i> Last <i>TALOR</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO. <i>217-50-2736</i>		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>bronchial pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sarcoidosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>135 X</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>6 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased, from <i>2-14</i> , 19 <i>69</i> , to <i>3-18</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3-17</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Neil R Taylor Sr</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-18-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Neil R Taylor Sr</i>		22e. ADDRESS <i>Rising Sun, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>3/21/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MOUNT CALVERT</i>		23d. LOCATION (City or Town) (County) (State) <i>ABERDEEN HARFORD, MD.</i>			
24. FUNERAL DIRECTOR <i>Ralph M. Reed</i>		ADDRESS <i>RALPH M. REED, RISING SUN, MD.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 20 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

08887

RECEIVED

1940

Handwritten notes and stamps, including "RECEIVED" and "1940".

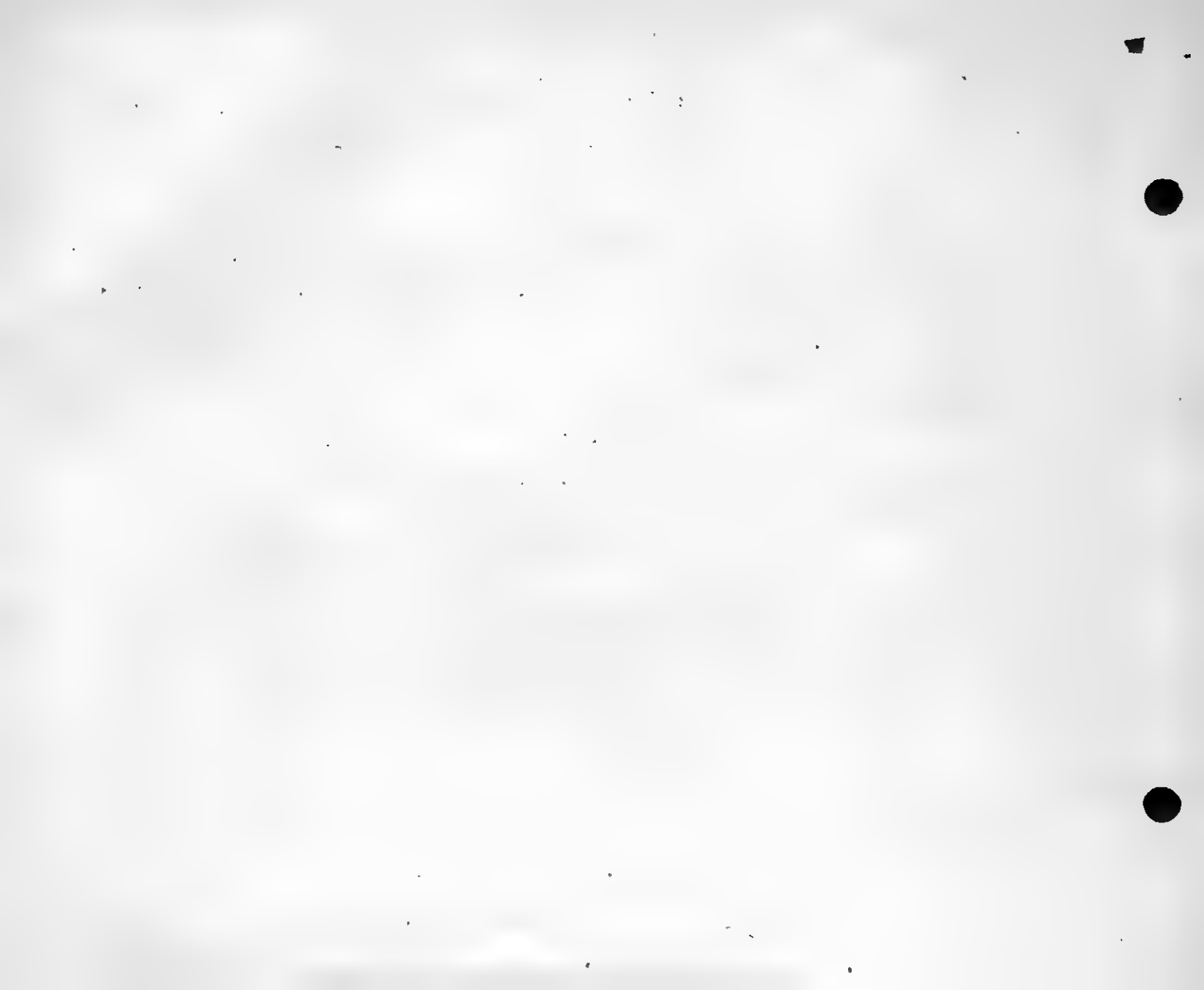
Handwritten notes, possibly "Handwritten" and "Notes".

Handwritten notes and stamps, including "RECEIVED" and "1940".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03928										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03922																			
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																			
First WILLIAM Middle LOUIS Last BRINEY										Month 2, Day 1969										9:45 p M																			
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)			7 UNDER 1 YEAR			8 UNDER 1 YEAR			9 UNDER 24 HRS																					
Male			Caucasian			October 10, 1916			52 YRS.			MONTHS			DAYS			HOURS																					
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH										Md.																				
Maryland			U.S.A.						Harford																														
10 CITY OR TOWN OF DEATH					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b KIND OF BUSINESS OR INDUSTRY																								
Churchville					Route #1					Appliance mechanic					Gas Company																								
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b COUNTY					13c CITY OR TOWN					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e STREET AND NUMBER																			
Maryland					Harford					Churchville					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					Route #1, Box 538																			
14 FATHER'S NAME First Middle Last					15 MOTHER'S MAIDEN NAME First Middle Last																																		
William M. Briney (D)					Lenora Hanna (D)																																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16b. SOCIAL SECURITY NO.					17 INFORMANT Address																													
No					217-03-4568					Wife, Churchville, Maryland																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																								
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma, rectum</u>															Circosis																								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple Metastasis</u>																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u></u>																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>68</u> , to <u>Mar</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 2</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE <u>J. Ralph Horky</u>										DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED <u>3/4/69</u>																			
22d. PHYSICIAN'S NAME (Type) <u>J. Ralph Horky, M.D.</u>										22e. ADDRESS <u>Churchville, Maryland 21028</u>																													
23a BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)									
Burial										5 March 1969										Bel Air Memorial Gardens										Bel Air (Harford Co.) Md.									
24 FUNERAL DIRECTOR <u>Kenneth B. Ganga</u>										ADDRESS <u>Tarring Funeral Home, Aberdeen, Md. 21001</u>										25a READ BY REGISTRAR <u>MAR 6 1969</u>										25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-10. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

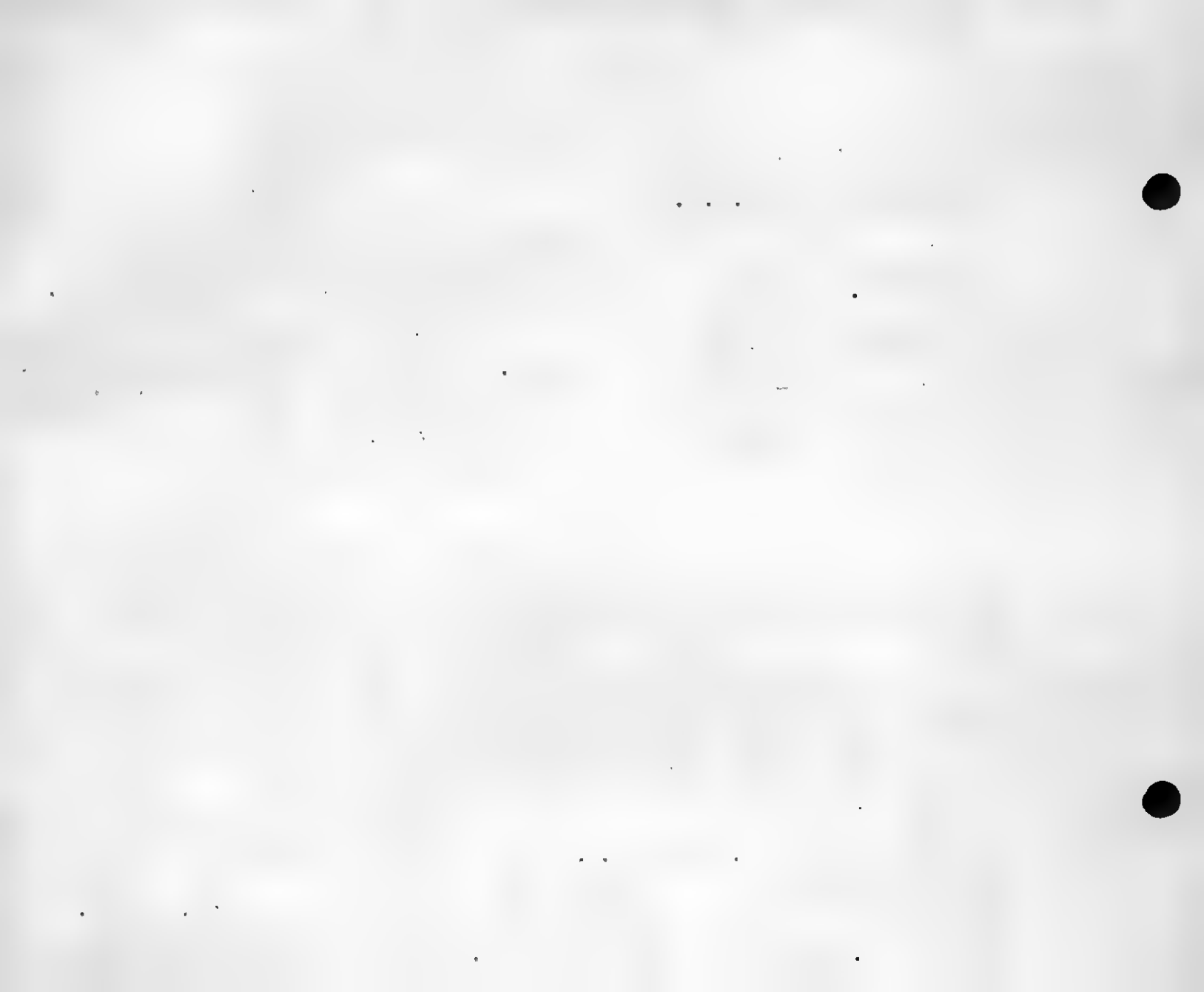
03929

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03923

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year			2b HOUR							
Lucy Belle Brown						March 16						M							
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR					
F		W		5/28/1909		59 YRS		MONTHS DAYS		HOURS MIN		Month March Day 11 Year 1969		535 M					
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED				9. COUNTY OF DEATH							
Virginia				U.S.A.				WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Harford Md.							
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY							
Street				Trepp Road XXXXXXXXXXXXXXXXXX 009				Housewife				Home							
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS?				13e STREET AND NUMBER			
Md.				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				5902 Glen Falls Ave.							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
First Middle Last						First Middle Last													
Lawson Blevins						Alvirda Neaves													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b SOCIAL SECURITY NO						17 INFORMANT							
No						180-22-3139						Mrs. Earl Crowther Box 381B Sandy Hook Rd. Forest Hill, Md. 21050							
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
DUE TO, OR AS A CONSEQUENCE OF																			
DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a DATE OF OPERATION						19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)											
				HOUR A.M. P.M. 19															
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No				City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> Be/ A. n. d.						22b DATE SIGNED							
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						3-11-69							
ADDRESS						25a REC'D BY REGISTRAR						25b REGISTRAR'S SIGNATURE							
23a BURIAL, CREMATION REMOVAL (Specify)						23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)							
Burial						3/15/1969		New Freedom				New Freedom, Penna.							
24 FUNERAL DIRECTOR						ADDRESS						25a REC'D BY REGISTRAR							
Charles E. Kurtz Jarrettsville, Md.						21084						DATE 3-11-69							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AND 45M 1969

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03930

03924

1 DECEASED NAME (Type or print) ^{First} <u>Herbert</u> ^{Middle} <u>Abner</u> ^{Last} <u>Budnick</u>			2a. DATE OF DEATH ^{Month} <u>MARCH</u> ^{Day} <u>27</u> ^{Year} <u>69</u>		2b. HOUR <u>10:45</u> ^{AM} <u>PM</u>
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH <u>December 15, 1895</u>		6. AGE (In years last birthday) <u>73</u> YRS	7. UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>
7a. BIRTHPLACE (State or foreign country) <u>Md</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Harford</u> ^{Md}	
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Harford Memorial Hosp</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Foreman</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <u>Md</u>		13b. COUNTY <u>Harford</u> ^{Joppa}		13c. STREET AND NUMBER <u>1114 Mt. Rd.</u>	
14. FATHER'S NAME ^{First} <u>Albert</u> ^{Middle} <u>James</u> ^{Last} <u>Budnick</u>		15. MOTHER'S MAIDEN NAME ^{First} <u>Ellen</u> ^{Middle} <u>Isabella</u> ^{Last} <u>Gardner</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>Yes</u> (If yes give war or dates of service) <u>WWI</u>	
16b. SOCIAL SECURITY NO <u>705-09-7386</u>		17. INFORMANT <u>Mrs. Helen Budnick, 1114 Mountain Road</u> ^{Joppa, Md.}			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arterio-sclerotic Myocardial Infarction</u> (b) <u>ASCD, Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>ASCD, Congestive Heart Failure</u> (c) <u>ASCD, Congestive Heart Failure</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY ^{HOUR A.M.} <u>19</u> ^{Month} <u>3</u> ^{Day} <u>16</u> ^{Year} <u>1969</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED ^{While} <input type="checkbox"/> ^{Not while} <input type="checkbox"/> ^{at work} <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION ^{Street or R.F.D. No.} <u>3-16</u> ^{City or Town} <u>Joppa</u> ^{County} <u>Harford</u> ^{State} <u>Md.</u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-16</u> , 19 <u>69</u> , to <u>3-27</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-27</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>DAVID H. MONAHAN, M.D.</u>		22c. DATE SIGNED <u>5/27/69</u>		22d. PHYSICIAN'S NAME (Type) <u>DAVID H. MONAHAN, M.D.</u>	
22e. ADDRESS <u>2114 Union Ave. Hagerstown, Md.</u>		23a. B. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE <u>Mar. 29, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery</u>		23d. LOCATION (City or Town) <u>Joppa</u> (County) <u>Harford</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 1 1969</u>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove **pages 1 and 2** and place them in the envelope provided. This certificate should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03931

CERTIFICATE OF DEATH

03925

1. DECEASED NAME (Type or print) Karlina			First Middle Last Cain			2a. DATE OF DEATH Month 3 Day 5 Year 69			2b. HOUR 3:45pm		
3 SEX Female			4 RACE White			5 DATE OF BIRTH Sept. 24, 1892			6 AGE (In years lost birthday) 76 YRS		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford		
10 CITY OR TOWN OF DEATH Havre de Grace			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizens Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laundress			12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Cecil			13c. CITY OR TOWN Port Deposit			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 72 N. Main Street			14 FATHER'S NAME First William Middle Cain Last Hamm			15 MOTHER'S M.A.D.E.N. NAME First Louisa Middle S. Last Hamm					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 220-48-8794			17 INFORMANT Mary Renaldi, Port Deposit, Maryland 21904					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Chronic Cardiac Failure 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture Left Hip- DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept 9, 1967 , to March 5, 1969 , that (I) (we) last saw the deceased alive on March 5, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Clarence I. Benson M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED March 6-1969		
22d. PHYSICIAN'S NAME (Type) Clarence I. Benson M.D.						22e. ADDRESS Box 123 Port Deposit, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/8/1969			23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cemetery			23d. LOCATION (City or Town) (County) (State) Colona Cecil Md.		
24. FUNERAL DIRECTOR Lee A. Patterson & Son						ADDRESS Perryville, Md.			25a. REC'D BY REGISTRAR MAR 11 1969		
									25b. REGISTRAR'S SIGNATURE Clarence Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, when the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First		M'ddle		Last		2a. DATE OF DEATH	
Myrtle		Vivian		Cersley				Month 3 Day 30 Year 69	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
Female		White		8-14-1900		68 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Dist of Columbia		USA				Harford			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
HARPER GRACE		Citizens Nursing Home		Sales Lady		Dept. Store			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admss an)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE C.T.Y. LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Harford		Bel Air				108 W Lynbrook Place	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Charles David		Laura Donnie		Easton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		217-05-8781		Daughter 838-5066		108 West Lynbrook Place			
				Mrs. Juanita C. Bowetson		Bel Air, Maryland 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Sudden Cardiac Deкомпensation									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Sudden Coronary Insufficiency									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Generalized Arteriosclerosis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 3-6-1969, to 3-30-1969, that (I) (we) lost saw the deceased alive on 3-30-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
DAVIDE U. MONAKIL, M.D.						3/30/69.			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
DAVIDE U. MONAKIL, M.D.		21 N. Union Ave.		Harred Grace Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 3, 1969		DADE Memorial Park		Miami, Dade Co., Florida 33137			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph William Foster		10 Broadway & Williams Street		APR 2 1969		J. C. Mullen			
		Bel Air, Maryland 21014							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

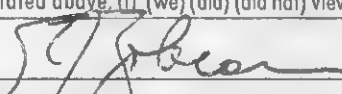

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03933

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03927

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Thomas W. Cush			2a. DATE OF DEATH 3 Month 18 Day 69 Year			2b. HOUR 0310 M					
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH 9 Feb 1920		6 AGE (In years lost birthday) 49 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.					
10. CITY OR TOWN OF DEATH A.P.G.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kirk Army Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Soldier			12b KIND OF BUSINESS OR INDUSTRY US Army			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b COUNTY Harford		13c CITY OR TOWN A.P.G.		13d INSIDE CITY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER HHC 1ST BN			
14. FATHER'S NAME First Middle Last Deceased, Unknown				15. MOTHER'S MA DEN NAME First Middle Last Deceased, Unknown							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		(If yes give war or dates of service) 10 Jan 45		16b SOCIAL SECURITY NO. 054-03-6479		17 INFORMANT U.S. Army Records		Address Aberdeen Proving Gd. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY 4109 IMMEDIATE CAUSE (a) Possible Coronary Artery Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Min											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 18 March 1969			
22d. PHYSICIAN'S NAME (Type) E.J. Zobian, Cpt, MC				22e. ADDRESS US Kirk Army Hosp, A.P.G. Md. 21005							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 3-21-69		23c NAME OF CEMETERY OR CREMATORY Long Island National		23d. LOCATION (City or Town) (County) (State) Farmingdale Nassau N.Y.					
24 FUNERAL DIRECTOR Capt Paul R. Branch				ADDRESS Home North East Md		25a REC'D BY REGISTRAR MAR 21 1969		25b REGISTRAR'S SIGNATURE 			



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03934

CERTIFICATE OF DEATH

03928

1. DECEASED-NAME (Type or print) First Middle Last William Joseph Day			2a. DATE OF DEATH Month Day Year March 2 1969			2b. HOUR 1745 M	
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 2 March 1969		6. AGE (In years last birthday) YRS. MONTHS DAYS 10 30	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.	
10. CITY OR TOWN OF DEATH APG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KAH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) 777X		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 22 B Bel Air Ave.							
14. FATHER'S NAME First Middle Last Griffin Franklin Day			15. MOTHER'S MAIDEN NAME First Middle Last Valeria G Tuttle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO.		17. INFORMANT Address Griffin Day 22 B Bel Air Ave, Aberdeen, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (2 lbs 3 oz) 777X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 1/2 hrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 0715 3-2, 1969 to 1745 3-2, 1969 , that (I) (we) last saw the deceased alive on 3-2 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John H. Niles</i>		22c. DATE SIGNED March 2, 1969		22d. PHYSICIAN'S NAME (Type) JOHN H. NILES, CPT, MC			
22e. ADDRESS US KIRK ARMY HOSPITAL, APG, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7 Mar. 69		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Ft Myer, Virginia		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Tarring Funeral Home</i>				25a. REC'D BY REGISTRAR MAR 7 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03935 CERTIFICATE OF DEATH 03929											
1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY HARFORD					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BEL AIR (RFD)				c. LENGTH OF STAY IN 1b 27 YRS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BEL AIR (RFD)				d. STREET ADDRESS 309 FOUNTAIN GREEN Rd	
3. NAME OF DECEASED (Type or print) CLAY WASHINGTON EDWARDS						4. DATE OF DEATH MARCH 6 1969		5. SEX MALE		6. COLOR OR RACE CAUCASIAN	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH DEC 30, 1901		9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		11. BIRTHPLACE (County & State, or foreign country) ALLEGHANY, No. CAR.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CENTER J. EDWARDS				14. MOTHER'S MAIDEN NAME FLORENCE CAUDILL				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 238-30-5286	
17. INFORMANT (Name) Mrs. Christine R. Edwards Address 309 Fountain Green Road, Bel Air, Maryland 21014											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CONGESTIVE FAILURE - PULMONARY EDEMA											
DUE TO (b) EMPHSEMA											
DUE TO (c) OVER 5 YRS											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 DAYS											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from DEC 1953 to MARCH 1969 , that (I) (we) last saw the deceased alive on MARCH 6, 1969 , and that death occurred at 1:00 PM , from the causes and on the date stated above.											
22a. SIGNATURE Philip W. Heuman						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED MARCH 6, 1969			
22c. PHYSICIAN'S NAME (Type) PHILIP W. HEUMAN, M.D.						22d. ADDRESS 307 HICKORY AVE., BEL AIR, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF MARCH 8, 1969		23c. NAME OF CEMETERY OR CREMATORY Emory Methodist Church Cem.				23d. LOCATION (City, town or county) (State) Street Harford Co., Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph William Foster						ADDRESS W. Broadway & Williams Street, Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR MAR 10 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

1915
28280

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbons, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
James G. Blaine Fisher						Month	Day	Year	12:00 P.
3 SEX	4. RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)	IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
Male	Caucasian		January 5, 1891			78			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Maryland	USA					Harford County Md.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace			Citizens Nursing Home			Railroad Conductor		Rail Road	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Harford	Perryville					
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First
George Fisher						Annie Hines			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT			
Yes, no (or unknown)			WWII			Miss Elsie O. Fisher, Havre de Grace, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Congestive Heart Failure & Pulmonary Edema									
DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Diabetes Mellitus & Anemia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION			
						Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 16, 1969, to Mar 27, 1969, that (I) (we) last saw the deceased alive on Mar 27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Charles J. Foley Jr.						Mar 27, 1969			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
CHARLES J. FOLEY JR.						Havre de Grace, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			4/2/69		Liberty Cemetery		Perryville, Harford Co., Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. H. Patterson, Jr., Perryville, Md.						APR 3 1969		Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>1</div> <div> <div>03937</div> <div>03931</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div>											
1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 118 Maulsby Ave.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air d. STREET ADDRESS 118 Maulsby Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HARRY ALBERT FLAHART			4. DATE OF DEATH March 31, 1969			5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 7/17/1902			9. AGE (In years last birthday) 66 yrs.			10. IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Min. 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment operator				10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric				11. BIRTHPLACE (County & State, or foreign country) Penna.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.						13. FATHER'S NAME William James Flahart					
14. MOTHER'S MAIDEN NAME Ella Dampman						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					
16. SOCIAL SECURITY NO. 213-26-3281						17. INFORMANT Mrs. Margaret E. Flahart					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pulmonary Fibrosis DUE TO Emphysema + Bronchectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 84ns DUE TO (c) 21014 INTERVAL BETWEEN ONSET AND DEATH 24ns						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from MARCH 27, 1969 , to MARCH 31, 1969 , that (I) (we) last saw the deceased alive on MARCH 27, 1969 , and that death occurred at 12:00 AM , from the causes and on the date stated above.							
22a. SIGNATURE Dudley Phillips				22b. DATE SIGNED 3/31/69				22c. PHYSICIAN'S NAME (Type) Dudley Phillips MD			
22d. ADDRESS DARLINGTON, MD 21034				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
23b. DATE THEREOF 4/2/1969				23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens				23d. LOCATION (City, town or county) (State) Bel Air, Harford, Md.			
24. FUNERAL DIRECTOR Charles E. Kurtz				24b. ADDRESS Jarrettsville, Md.				25a. REC'D BY REGISTRAR APR 3 1969			
25b. REGISTRAR'S SIGNATURE Charles E. Kurtz											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03938

CERTIFICATE OF DEATH

03932

1. DECEASED NAME (Type or print) <i>Mary Ella Ford</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>29</i> Year <i>69</i>			2b. HOUR <i>4:45</i> M					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>December 23, 1887</i>		6. AGE (In years last birthday) <i>81</i> YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD.</i>					
10. CITY OR TOWN OF DEATH <i>Harrods-Grace</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>			13b. COUNTY <i>Harford</i>			13c. CITY OR TOWN <i>Bel Air</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <i>1045 Reid St</i>			14. FATHER'S NAME First <i>H. Nelson</i> Middle <i>E.</i> Last <i>Agutline</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Matthia</i> Last <i>Michael</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <i>217-22-0704</i>			17. INFORMANT (NEICE 538-4512) Mrs. Isabelle S. Rogers <i>308 Franklin Street Bel Air, Maryland 21014</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Decomposition</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i> keto acidosis & dehydration</i> (c) <i> severe Brittle Diabetic Mellitus</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Ulceration ulcers.</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2-28, 1969</i> , to <i>3-29, 1969</i> , that (I) (we) last saw the deceased alive on <i>3-29, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <i>Dante N. Monakil, M.D.</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>3/29/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>DANTE N. MONAKIL</i>						22e. ADDRESS <i>211 W. Union Ave. Harrods-Grace, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>April 1, 1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Episcopal Church Cem.</i>			23d. LOCATION (City or Town) (County) (State) <i>Rocks, Harford Co, Maryland</i>		
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>						ADDRESS <i>W. Broadway & Williams St. Bel Air, Maryland 21014</i>			25a. REC'D BY REGISTRAR DATE <i>APR 2 1969</i>		
									25b. REGISTRAR'S SIGNATURE <i>Orlando J. Jones</i>		



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
039339 CERTIFICATE OF DEATH 039339									
1 DECEASED NAME (Type or print)			First Middle Last Baby Girl Haga			2a. DATE OF DEATH Month Day Year March 22 1969			2b. HOUR 12:55 PM
3 SEX Female		4 RACE white		5 DATE OF BIRTH March 21, 1969			6 AGE (in years last birthday) YRS		7 UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md			
10. CITY OR TOWN OF DEATH Havre de Grace			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp.			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) none			12b KIND OF BUSINESS OR INDUSTRY none
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md			13b COUNTY HARFORD		13c CITY OR TOWN Edgewood		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2017 Rockwell St
14 FATHER'S NAME First Middle Last Clarence -- Haga			15. MOTHER'S MAIDEN NAME First Middle Last Patricia Ann Miller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b SOCIAL SECURITY NO none		17. INFORMANT Address Mr. Miller, 16 Right Elevator Drive, Middle River, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7701 immaturity DUE TO, OR AS A CONSEQUENCE OF premature labor (b) DUE TO, OR AS A CONSEQUENCE OF abruptio placentae (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3-21, 1969, to 3-22, 1969, that (I) (we) last saw the deceased alive on 3-22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE John A. Carriere, M.D.						22c DATE SIGNED		22d. PHYSICIAN'S NAME (Type) John A. Carriere, M.D.	
22e ADDRESS 607 S. Union Ave., Havre de Grace, Md.									
23a BURIAL CREMATION, REMOVAL (Specify) Burial			23b DATE Mar. 24, 1969		23c NAME OF CEMETERY OR CREMATORY Harford Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Aldino Harford Md.		
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.						25a RECD BY REGISTRAR DATE MAR 26 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit when please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-58

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03940											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) First Middle Last MARY Edna HANSON						2a. DATE OF DEATH Month Day Year March 3, 1969			2b. HOUR 6:30 AM		
3. SEX Female		4 RACE White		5. DATE OF BIRTH 20 July 1886		6 AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Md		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md					
10 CITY OR TOWN OF DEATH HAURE DE GRACE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress			12b K NO OF BUSINESS OR INDUSTRY		
13a U.S. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md			13b. COUNTY HARFORD		13c CITY OR TOWN Churchville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER RD 1 Box 62		
14 FATHER'S NAME First Middle Last Frederick Hanson						15 MOTHER'S MAIDEN NAME First Middle Last Eliza Preston					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no				16b SOCIAL SECURITY NO. 215 07 5891		17 INFORMANT Address Ed Mitchell Churchville, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of Sigmoid</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 1-22-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Rectal Bleeding				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 21, 1969, to March 3, 1969, that (I) (we) last saw the deceased alive on March 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles J. Foley Jr. M.D.						22c. DATE SIGNED 3/3/69		22d. PHYSICIAN'S NAME (Type) CHARLES J. FOLEY JR.			
22e. ADDRESS HAURE DE GRACE, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5 Mar 69		23c. NAME OF CEMETERY OR CREMATORY Churchville Presbyterian		23d. LOCATION (City or Town) (County) (State) Churchville Harford, Md.					
24. FUNERAL DIRECTOR Tarring Funeral Home Aberdeen, Maryland 21001						25a. REC'D BY REGISTRAR MAR 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M 1 69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03935
CERTIFICATE OF DEATH

03941

1 DECEASED NAME (Type or print) John First Hein Middle Hein Last		2a. DATE OF DEATH Month 3 Day 27 Year 69		2b. HOUR 9:53 AM
3 SEX Male	4 RACE White	5. DATE OF BIRTH 8/25/1893	6. AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Harford Md.	
10. CITY OR TOWN OF DEATH Harrode-Grace	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Pa. P.R.	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.	13b. COUNTY Harford	13c. CITY OR TOWN Harrode-Grace	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 453 Green St.
14 FATHER'S NAME First Julius Middle Hein Last	15 MOTHER'S MAIDEN NAME First Susan Middle Quilla Last Spindler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. unk	17 INFORMANT Myrtle J. Hein Address 453 Green St. Harrode-Grace Md		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal Uremia 403X DUE TO, OR AS A CONSEQUENCE OF Chromalophrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis (c) Generalized Arteriosclerosis				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. PM Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3-27, 1969 to 3-27, 1969 , that (I) (we) last saw the deceased alive on 3-27, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death				
22b. SIGNATURE Dante U. Monakil, M.D. DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 3-27-69	
22d. PHYSICIAN'S NAME (Type) DANTE U. MONAKIL, M.D.		22e. ADDRESS 211 W. Union Ave. Harrode-Grace, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3/31/69	23c. NAME OF CEMETERY OR CREMATORY Coakley	23d. LOCATION (City or Town) (County) (State) Harrode-Grace Md	
24. FUNERAL DIRECTOR Joseph P. Hurd		ADDRESS Harrode-Grace Md	25a. RECD BY REGISTRAR APR 2 1969	25b. REGISTRAR'S SIGNATURE Charles Hurd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

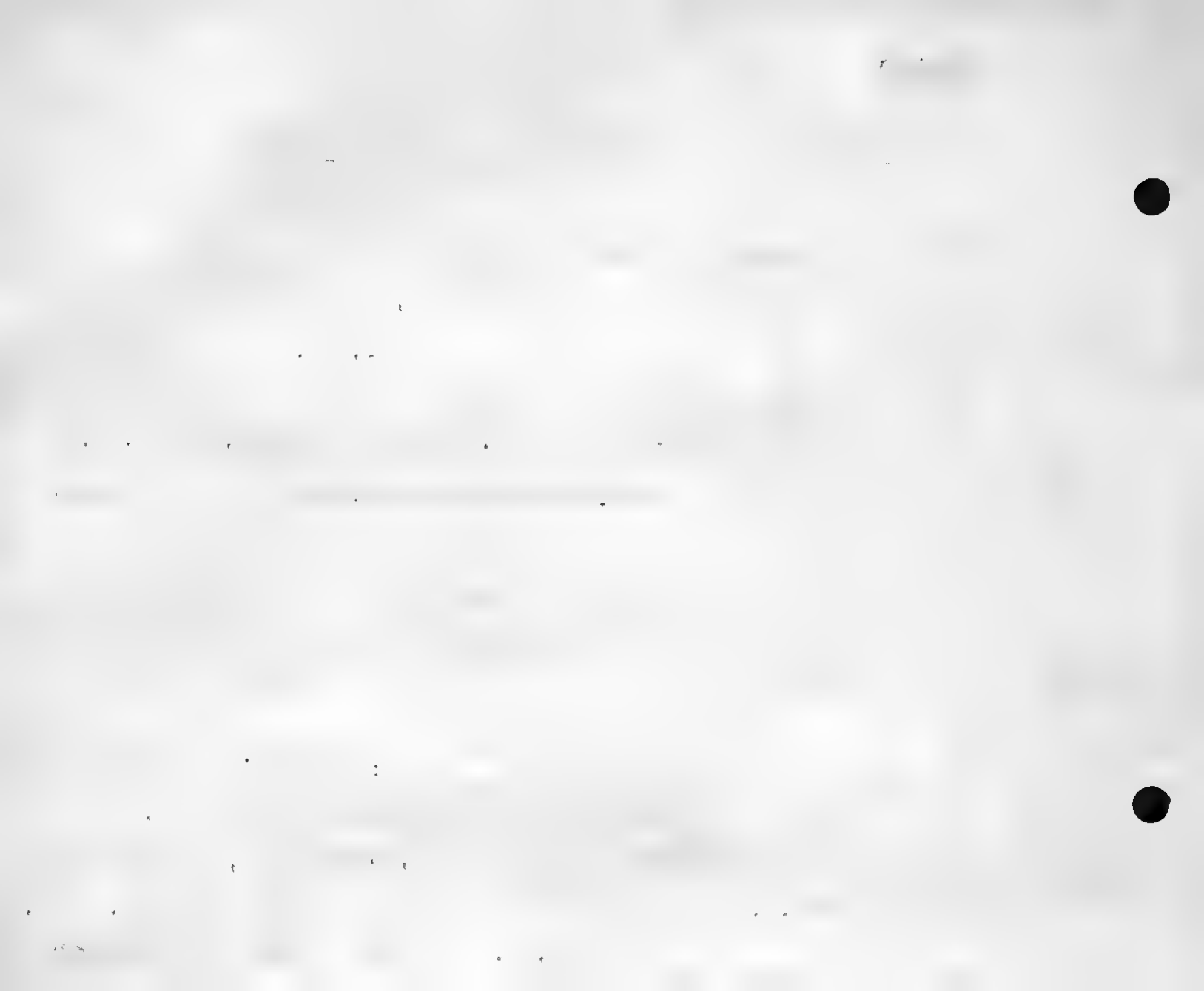
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03942

03936

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Street c. LENGTH OF STAY IN 1b 1 year d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Street d. STREET ADDRESS Ady Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Vernon Last Hensley				4. DATE OF DEATH Month March Day 29 Year 19 69			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1916	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 52 Hours 52 Min.		IF UNDER 24 HRS. Months 52 Days 52 Hours 52 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wise Co., Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry Hensley				14. MOTHER'S MAIDEN NAME Zuella Hash			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 401-01-4073		17. INFORMANT Address Mrs. Margaret Hensley, Street, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prob. bronchogenic Carcinoma 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1950 to Mar. 29, 1969 , that (I) (we) last saw the deceased alive on March 28 1969 , and that death occurred at 10:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Robert Barthel				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Mar. 31/69	
22c. PHYSICIAN'S NAME (Type) Robert Barthel				22d. ADDRESS Box 4, Forest Hill, Maryland 21050			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Hensley Family Cem.		23d. LOCATION (City, town or county) (State) Norton Wise Co. Va.	
24. FUNERAL DIRECTOR JOHN H. HARKINS				ADDRESS Delta, Pa.		25a. REC'D BY REGISTRAR APR 7 1969	
						25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03943									
CERTIFICATE OF DEATH									
03937									
1 DECEASED NAME (Type or print) Baby Boy Hilaman			2a. DATE OF DEATH Month MARCH Day 7 Year 1969			2b. HOUR 11:30			
3. SEX male		4. RACE white		5. DATE OF BIRTH 3-6-69		6. AGE (In years lost birthday) — YRS.		7. IF UNDER 1 YEAR MONTHS 1 DAYS 17 HOURS 44	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD			
10. CITY OR TOWN OF DEATH HAVER de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE PA.		13b. COUNTY Chester		13c. CITY OR TOWN OXFORD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. Box 23	
14. FATHER'S NAME First Edwin C. Middle Hilaman Last Hilaman			15. MOTHER'S MAIDEN NAME First Elva Middle Agnes Last Jensenberry						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (or of unknown) <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO —		17. INFORMANT Edwin C. Hilaman Oxford Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CIRCULATORY + RESPIRATORY FAILURE									
DUE TO, OR AS A CONSEQUENCE OF (b) CENTRAL NERVOUS SYSTEM FAILURE									
DUE TO, OR AS A CONSEQUENCE OF (c) —									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) —									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3-6-1969 , to 3-7-1969 , that (I) (we) lost the deceased alive on 3-7-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE K. Namor MD		22c. DATE SIGNED 3-8-69		22d. PHYSICIAN'S NAME (Type) K. Namor					
22e. ADDRESS HAVER de Grace Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-9-1969		23c. NAME OF CEMETERY OR CREMATORY Oxford Cem.		23d. LOCATION (City or Town) (County) (State) Oxford Chester PA.			
24. FUNERAL DIRECTOR James H. Mullen		24a. REC'D BY REGISTRAR March 12 1969		24b. REGISTRAR'S SIGNATURE James H. Mullen					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03944

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03938

1. DECEASED-NAME (Type or print) <i>Flourence E. Jenkins</i>		2a. DATE OF DEATH Month <i>3</i> Day <i>15</i> Year <i>1969</i>		2b. HOUR M <i></i>	
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>Sept. 14, 1911</i>	
6. AGE (In years lost birthday) <i>57</i> YRS.		7. UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		8. UNDER 24 HRS HOURS <i></i> MIN <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Northport, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. COUNTY OF DEATH <i>Harford</i>		10. CITY OR TOWN OF DEATH <i>Harre de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>552 Pennington St.</i>	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Coach Cleaner</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Penn Central</i>		13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Maryland</i>	
13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Harre de Grace</i>		3a. INSIDE CITY, LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13d. STREET AND NUMBER <i>552 Pennington Ave.</i>		14. FATHER'S NAME First <i>Arthur E.</i> Middle <i></i> Last <i>Hawkins</i>		15. MOTHER'S MAIDEN NAME First <i>Eva</i> Middle <i></i> Last <i>Taylor</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>721-18-3592</i>		17. INFORMANT Name <i>Mrs. Bertha C. Hawkins</i> Address <i>Harre de Grace, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous Anaplastic</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <i>2/25/69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Massive GI. Hemorrhage associated with Metastatic Neoplastic Disease</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>2/2</i> , 19 <i>69</i> , to <i>3/15</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/14</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>George T. Stansbury, M.D.</i>		22c. DATE SIGNED <i>3/15/69</i>		22d. PHYSICIAN'S NAME (Type) <i>George T. Stansbury, M.D.</i>	
22e. ADDRESS <i>569 Revolution St. Harre de Grace, Md.</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			
23b. DATE <i>3/19/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. James A.M.E. Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Harre de Grace, Harford - Md.</i>	
24. FUNERAL DIRECTOR <i>Othelia G. Bullock, Harre de Grace, Md. 21072</i>		25a. REC'D BY REGISTRAR <i></i>		25b. REGISTRAR'S SIGNATURE <i></i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b TIME 1:50 PM
William Charles Johnson					March	12	69	
3 SEX	4. RACE		5 DATE OF BIRTH		6 AGE (In years last b.rthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
male	white		9-9-88		80 YRS			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Md.	USA				Harford			
1d CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of year, even if retired)		12b KIND OF BUSINESS OR INDUSTRY
Harre de Grace			Citizens Nursing Home			Saw Milling		Saw Mill
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER
Md.			Harford					Jarrettsville Road
14. FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last				
George W. Johnson				Catherine Adams				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.			17 INFORMANT		
No			218-34-0705			Mrs. Jarrettsville Road Lillie M. Johnson Forest Hill, Md		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Unlabeled Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S. C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>3-4 years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a) <u>Senility</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/12/68</u> , 19 <u>68</u> , to <u>3/14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/14</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <u>Edward C. Loomis</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>3/14/69</u>		
22d PHYSICIAN'S NAME (Type) <u>Edward C. Loomis, M.D.</u>				22e ADDRESS <u>Harre de Grace, Ind.</u>				
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		3/17/1969		Jarrettsville		Jarrettsville, Maryland		
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE
Charles E. Kurtz Jarrettsville, Md.						MAR 17 1969		<u>W. Charles Kurtz</u>

FOR STATE HEALTH DEPT.

03946

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03940

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Edward Valentine Kern					March 2		19			M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. UNDER 1 YEAR		8. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male	White	May 10, 1897		71 YRS	MONTHS		HOURS		March 2, 1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		2d. HOUR
		USA		WIDOWED		DIVORCED		Harford		5:45 PM
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUA. OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Joppa		2500 Winters Run Rd.				Farmer		Agric.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Harford		Joppa		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2500 Winters Run Road		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
John		--		Kern	Emma		--		McCormick	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		
WWI - Yes		WWI		218-26-9169-A		Mrs. Ruth K. Morlok		319 Edmund St., Aberdeen Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE										IN SLEEP
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										OVER 2 YR.
(b) CONGESTIVE FAILURE										
(c) ARTERIO SCLEROSIS & CEREBRAL VASCULAR ACCIDENT										1966
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Philip W. Heuman				M.D.		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		Philip W. Heuman, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		March 2, 1969		
						ADDRESS (Street, city, town, or county)		Bel Air, Md.		
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		Mar. 5, 1969		Bel Air Memorial Gardens		Bel Air		Harford		Md.
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Howard K. McComas & Son, Abingdon, Md.						DATE MAR 4 1969		[Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03947

CERTIFICATE OF DEATH

03941

1 DECEASED NAME (Type or print) First Middle Last EVELYN GUSTNIA MAST			2a DATE OF DEATH Month Day Year March 26 1969			2b. HOUR M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH December 27, 1913		6 AGE (In years lost birthday) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Havre de Grace		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Assembler		12b KIND OF BUSINESS OR INDUSTRY Tool			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b COUNTY Harford		13c CITY OR TOWN Joppa		13d INS-DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2309 Mountain Road	
14. FATHER'S NAME First Middle Last Christopher -- Hoffman			15 MOTHER'S MAIDEN NAME First Middle Last Jennie -- Akeley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b SOCIAL SECURITY NO. (If yes give year or dates of service) 213-28-4327		17 INFORMANT Address Florence H. Suite, 2304 Martin Lane, Joppa, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 19 <u>69</u> , to <u>3-26</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Gerald C. Palmer</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Mar. 26, 1969			
22d. PHYSICIAN'S NAME (Type) Gerald C. Palmer, M.D.				22e. ADDRESS Bel Air, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 29, 1969		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d LOCATION (City or Town) (County) (State) Bel Air Harford Md			
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.				25a REC'D BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE <u>Gerald C. Palmer</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03948

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03942

1 DECEASED-NAME (Type or print) <i>Samuel Dewey May</i>			2a DATE OF DEATH Month <i>3</i> Day <i>14</i> Year <i>69</i>			2b HOUR <i>5:30</i> AM				
3 SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>3 July 1899</i>		6 AGE (n years last birthday) <i>69</i> YRS		F UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>N.C.</i>		7b. CITIZEN-OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD.</i> Md				
10. CITY OR TOWN OF DEATH <i>Three-de-Grace</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farmer (Ret.)</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Harford-Darlington</i>		13c. CITY OR TOWN <i>Darlington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Box 264 R#2 Darlington</i>		
14 FATHER'S NAME First Middle Last <i>William Henry May</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Almeda Eller</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a, or unknown) (If yes give war or dates of service) <i>No</i>			16b. SOCIAL SECURITY NO. <i>218-22-0770</i>		17 INFORMANT <i>Lucy V. May, R.D. 2, Darlington, Maryland</i>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Senile Pulmonary Bronchitis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Choke-brake imbalance and Chv.</i> DUE TO, OR AS A CONSEQUENCE OF <i>Summary Fibrosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 wks</i> <i>10 yrs</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Generalized arteriosclerosis</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 38)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>2-28, 1969</i> , to <i>3-14, 1969</i> , that (I) (we) lost saw the deceased alive on <i>3-14</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Dudley Phillips</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>3/14/69</i>				
22d. PHYSICIAN'S NAME (Type) <i>Dudley Phillips</i>				22e. ADDRESS <i>Darlington, Md 21034</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>17 Mar. 69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial Gardens</i>		23d. LOCATION (City or Town) <i>Bel Air (Harford Co.)</i>		(County) (State) <i>Md.</i>		
24. FUNERAL DIRECTOR ADDRESS <i>Tarring Funeral Home, Aberdeen, Md. 21001</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 18 1969</i>		25b. REGISTRAR'S SIGNATURE <i>James S. Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03949										
CERTIFICATE OF DEATH										
03943										
1 DECEASED NAME (Type or print) James George Meek			2a DATE OF DEATH Month March Day 25 Year 1969			2b HOUR 12:46 P.M.				
3 SEX MALE		4 RACE white		5 DATE OF BIRTH March 8, 1931		6 AGE (In years last birthday) 38 YRS		7 IF UNDER 1 YEAR MONTHS 1 DAYS 17 HOURS 46 MIN		
7a. BIRTHPLACE (State or foreign country) md		7b. CITIZEN OF WHAT COUNTRY? US.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.				
10 CITY OR TOWN OF DEATH HAURDE GRACE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD MEMORIAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanics			12b. KIND OF BUSINESS OR INDUSTRY Surge	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE md			13b. COUNTY HARFORD		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY, IN 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RD	
14 FATHER'S NAME First Joseph D. Middle Meek Last Shoda B. Barnes			15 MOTHER'S MAIDEN NAME First Shoda B. Middle Barnes Last Meek							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes, give branch and service) yes WHITE			16b. SOCIAL SECURITY NO. 813-12-455		17. INFORMANT Fath B. Meek, Port Deposit, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest and Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Cardiac Decompensation (c) Acute lymphatic Leukemia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bilateral Bronchopneumonia										
19a. DATE OF OPERATION 3/25/69			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardiac Arrest			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. 19 Month 3 Day 25 Year 1969			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Cardiac Arrest				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) at home			21c. LOCATION Street or R.F.D. No. 3/25 City or Town Port Deposit County Harford State Md.				
22a. I certify that (I) (this hospital) attended the deceased from 3/25 , 19 69 , to 3/25 , 19 69 , that (I) (we) last saw the deceased alive on March 25, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (d not) view the body after death.										
22b. SIGNATURE Edward C. Loo, M.D.			22c. DATE SIGNED 3/25/69			22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				
22e. ADDRESS Harford Memorial			22f. ADDRESS Harford Memorial							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/28/69		23c. NAME OF CEMETERY OR CREMATORY Harford Cemetery			23d. LOCATION (If by Town) (County) (State) Port Deposit Cecil Md.		
24. FUNERAL DIRECTOR See A. F. Fournier			25a. REC'D BY REGISTRAR APR 3 1969			25b. REGISTRAR'S SIGNATURE Charles Judge				



7



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)		First MARVIN		Middle CARL		Last MESSMAN		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3-2-69	
3 SEX Male	4 RACE White	5 DATE OF BIRTH April 8, 1920	6 AGE (in years last birthday) 48 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month March Day 2 Year 1969	2b. HOUR 12:20 M
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Bricklayer		12b. KIND OF BUSINESS OR INDUSTRY construction	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 1902 Philadelphia Road	
14. FATHER'S NAME First Howard Middle C. Last Messman			15. MOTHER'S MAIDEN NAME First Eva Middle Pearl Last Lanham			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWII			
16b. SOCIAL SECURITY NO 236-18-7145			17. INFORMANT Jack L. Messman, 377 Westchester Ave., Port Chester, N.Y.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Gerald C. Palmer		EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ADDRESS (Street, city town or county) Bel Air, Md.		22b. DATE SIGNED 3-3-69			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 4, 1969		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) Bel Air		(County) Harford	(State) Md.
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.				25a. REC'D BY REGISTRAR DATE MAR 4 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03951

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03945

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH	Month	Day	Year	2b HOUR
JOY DENISE MUMMERT					<input checked="" type="checkbox"/> March 13 1969				12 M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF LATER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD	Month	Day	Year
F	W	8/30/1967	1 YRS 7	MONTHS	DAYS	March 13 1969			130 M
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	9 COUNTY OF DEATH			
YORK Pa	USA	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HARFORD	Md		
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY						
HARFORD GRACE	HARFORD MEMORIAL	NONE	NONE						
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER					
MD	HARFORD	HARFORD GRACE	YES <input type="checkbox"/> NO <input type="checkbox"/>	929 QUARRY ROAD					
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last		
JACKIE L. MUMMERT				NANCY (NMI) CUNNINGHAM					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS						
NO	NONE	MR. JACKIE L. MUMMERT	929 QUARRY ROAD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ingestion Furniture Polish									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH		HOUR A.M. 19 P.M.		Drown Furniture Polish					
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Home		929 Quarry Road Harford County Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Gerald E Palmer				CHIEF MEDICAL EXAMINER <input type="checkbox"/> Ba/Act, Md.					
EXAMINER'S NAME (Type) Gerald E Palmer				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b DATE SIGNED 3-13-69					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		3/15/1969		MT ROSE CEMETERY		YORK Pa			
24 FUNERAL DIRECTOR				ADDRESS		25a RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Cunningham & Son, Harford Grace Md.						DATE MAR 17 1969		G. Palmer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

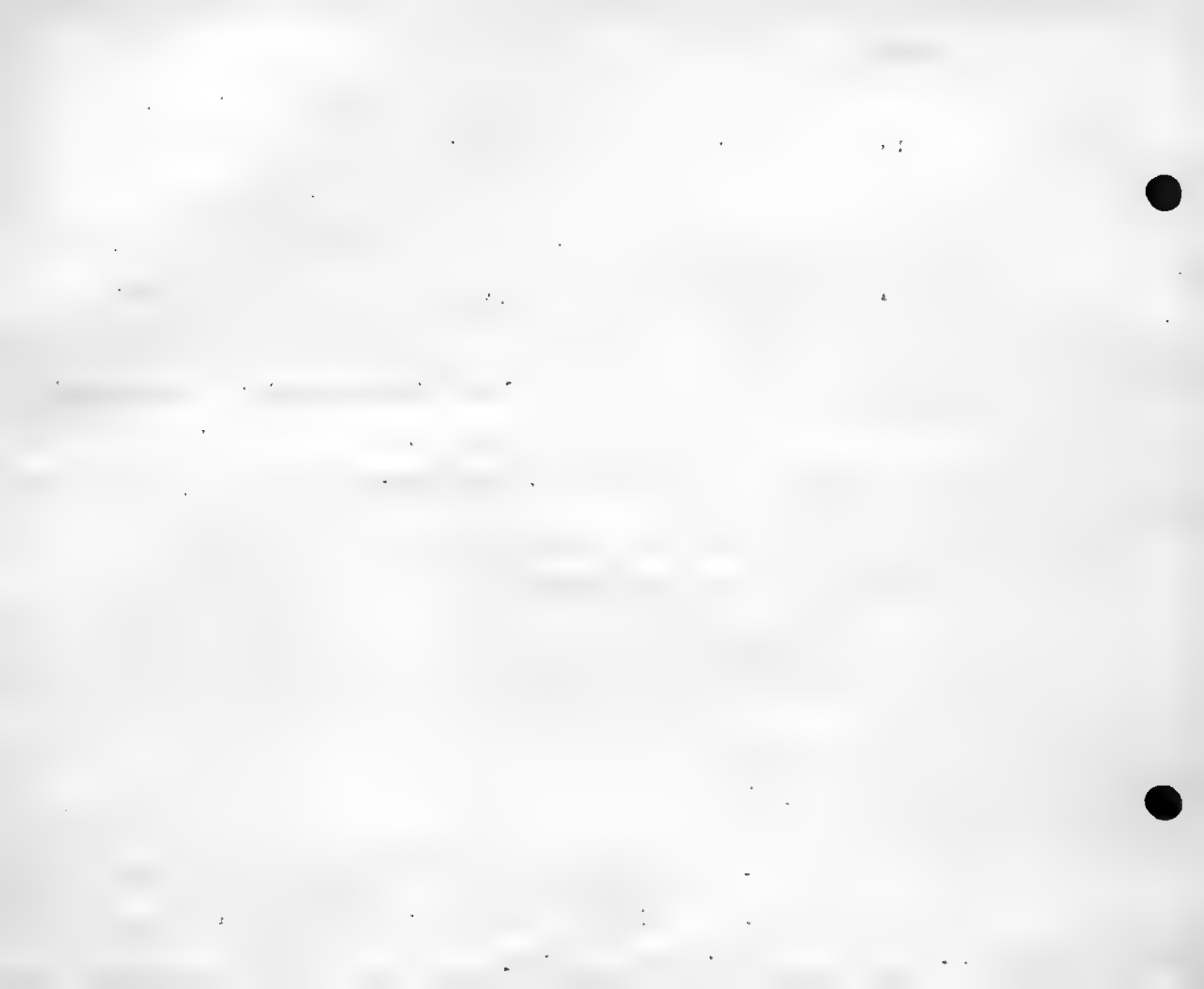
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03952

CERTIFICATE OF DEATH

03946

1. DECEASED NAME (Type or print) SELMA			First	Middle	Last	2a. DATE OF DEATH Month 11 Day 11 Year 1969			2b. HOUR 1:45 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH January 7, 1907		6. AGE (In years last birthday) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.				
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizens Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Teacher			12b. KIND OF BUSINESS OR INDUSTRY Teaching		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 453 Doris Circle		
14. FATHER'S NAME First John Middle F. Last Fox		15. MOTHER'S MAIDEN NAME First Mary Middle Guttermann Last Guttermann								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-46-1810		17. INFORMANT Address Raymond H. Nelson, Aberdeen, Md. 21001						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) chronic urinary tract infection										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5-24-64 to 3-11-69 , that (I) (we) last saw the deceased alive on 3-10-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE B.J. Plunkett Jr.					DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-11-69	
22d. PHYSICIAN'S NAME (Type) B.J. Plunkett Jr. M.D.					22e. ADDRESS 617 W. Bel Air Ave. Aberdeen, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 14 Mar. 69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland				
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001					25a. REC'D BY REGISTRAR MAR 13 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03953

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03947

1. DECEASED-NAME (Type or print) David Elmer Roberts			2a. DATE OF DEATH Month MARCH Day 8 Year 1969			2b. HOUR 3:15 MIN 4	
3. SEX Male		4. RACE White		5. DATE OF BIRTH November 7, 1903		6. AGE (In years last birthday) 65 YRS.	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) HARFORD Memorial Hosp		12a. USBA OCCUPATION (Kind of work done during most of working life, even if retired) Service Station Attnd.		12b. KIND OF BUSINESS OR INDUSTRY Service Sta.	
13a. USJAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MARYLAND		13b. COUNTY Harford		13c. CITY OR TOWN Perryman		13d. INSIDE CITY (H.M.T.S?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First David Middle R. Last Roberts (D)		15. MOTHER'S MAIDEN NAME First Lillian Middle Carr Last (D)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO			
16b. SOCIAL SECURITY NO 213-09-4928		17. INFORMANT Irene Schmechel, Aberdeen, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Submersion Embolism DUE TO, OR AS A CONSEQUENCE OF (c) 							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3-7 , 19 69 , to 3-8 , 19 69 , that (I) (we) lost saw the deceased alive on 3-8 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Norman Berger		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/8/69	
22d. PHYSICIAN'S NAME (Type) Norman Berger, M.D.		22e. ADDRESS Havre de Grace, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10 Mar. 69		23c. NAME OF CEMETERY OR CREMATORY Deer Creek Meth. Cemetery		23d. LOCATION (City or Town) (County) (State) Forest Hill, Maryland	
24. FUNERAL DIRECTOR Tarring Funeral Home		ADDRESS Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR MAR 11 1969		25b. REGISTRAR'S SIGNATURE William Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
03954			Barbara	Anna	Schenning	03	23	69	12:45
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		Caucasian		August 22, 1888		80 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		USA				Harford		farm	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace, Md.		Citizens Nursing Home		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Harford		Bel Air		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 132, RD. #2	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Martin					Vosald	Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no			215-36-8036		John E. Schenning, Box 132, R.D. #2, Bel Air		Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic CV Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced of Arteriosclerotic</u>								24 hrs 12 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Advanced of Arteriosclerotic</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Nov. 19 57, to March 19 69, that (I) (we) last saw the deceased alive on March 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Ralph Horky M.D.</u>					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <u>R. Ralph Horky</u>					22e. ADDRESS <u>Churchville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Mar. 26, 1969		Sacred Heart Cemetery		Baltimore		Md.	
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Howard K. McComas & Son, Abingdon, Md.					M.P. 26 1969				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03955		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03949	
Item #8, Filed 10/3/21/69 km							
1 DECEASED-NAME (Type or print)		First		Middle		Last	
EVERETT		C.		SCHRODER SR.			
2a DATE OF DEATH		Month		Day		Year	
March		15		1969			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	
Male		Caucasian		February 28, 1893		76 YRS.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Illinois		U.S.A.				Harford Md.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Havre de Grace		Harford Memorial Hospital		Printer (ret)		Printing	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Harford		Aberdeen		611 Northgate Road	
14. FATHER'S NAME		First		Middle		Last	
Roland Schroder		(D)		Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address	
No		216-32-6154		Everett C. Schroder Jr.		Aberdeen, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>							1/2 hr
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) _____							
DUE TO, OR AS A CONSEQUENCE OF							
(c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<u>coronary atherosclerosis</u>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'lly medical examiner)		21b. TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		HOUR A.M. Month Day Year P.M. 19					
21d INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work							
22a. I certify that (I) (this hospital) attended the deceased from <u>1-13-65</u> , 19 <u>65</u> , to <u>3-15-69</u> , 19 <u>69</u> , that (I) (we) saw the deceased alive on <u>3-12-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>B.J. Plunkett Jr.</u>		M.D.		617 W. Bel Air Ave. Aberdeen, Md. 21001		3-16-69	
22d PHYSICIAN'S NAME (Type)		22e ADDRESS					
B.J. Plunkett Jr. M.D.		617 W. Bel Air Ave. Aberdeen, Md. 21001					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		18 Mar 69		Meadowridge Memorial Park		Baltimore, Maryland	
24 FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Tarring Funeral Home, Aberdeen, Md. 21001				MAR 18 1969		<u>William Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03956 CERTIFICATE OF DEATH 03950									
1. DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR A
Elizabeth P. Simon						Month	Day	Year	11:50 AM
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (in years lost birthday)		IF UNDER 1 YEAR	
Female	Caucasian		December 19, 1984			84 YRS		MONTHS	DAYS
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland			USA				Harford Co., Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace			Citizens Nursing Home			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, IN TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Harford		Bel Air				126 Hickory Avenue Apt. 33, Hickory Court
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
Charles Wesley				Proctor		Sarah Elizabeth			Spencer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT EX-101-838-5067		Address		
NO			213-30-8182		Mrs. Helen J. Spencer		905 Rock Spring Road Bel Air, Maryland 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Gangrene of left leg</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.V.D</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>4124</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 months 5 yrs</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Arteriosclerosis fibulation</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				
John Yun		3/31/69			John D. Yun				
22e. ADDRESS		22f. ADDRESS			22g. ADDRESS				
Havre de Grace, Md		Havre de Grace, Md			Havre de Grace, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 2, 1969		Rock Spring Episcopal Church Cem.		Forest Hill, Harford Co., Maryland			
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Williams Foster		W. Broadway & Williams St. Bel Air, Maryland 21014		APR 2 1969		J. Williams Foster			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03957

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03951

1 DECEASED NAME (Type or print) <i>Alexander Guthrie Smith</i>			2a DATE OF DEATH Month <i>March</i> Day <i>7</i> Year <i>1969</i>			2b HOUR <i>11:30 PM</i>				
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>Sept. 28, 1885</i>		6 AGE (in years last birthday) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i>				
10 CITY OR TOWN OF DEATH <i>HAVER de Grace</i>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>HARFORD Memorial Hosp</i>			12a USUAL OCCUPATION (Kind of work done during part of working life, even if retired.) <i>Farmer</i>			12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>North East</i>		13d INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>R.D. 1, Box 96</i>	
14 FATHER'S NAME First <i>Edward B.</i> Middle <i>Smith</i> Last <i>Smith</i>			5 MOTHER'S MAIDEN NAME First <i>Hanna</i> Middle <i>Guthrie</i> Last <i>Guthrie</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>220-34-6121</i>			17. INFORMANT <i>McLain A. Smith</i>			Address <i>R.D. #1 North East Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i>									<i>5 days</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>A.S.C.V.D.</i>									?	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>3-4</i> , 19 <i>69</i> , to <i>3-7</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3-7</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Edward C. Zoo, M.D.</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/8/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>Edward C. Zoo, M.D.</i>						22e. ADDRESS <i>Haver de Grace, Md.</i>				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>3-11-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bay View Meth.</i>		23d. LOCATION (City or Town) (County) (State) <i>North East Cecil Md.</i>			
24. FUNERAL DIRECTOR <i>Grant Funeral Home</i>			ADDRESS <i>Box 42 North East, Md.</i>			25a REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03958

CERTIFICATE OF DEATH

03952

1. DECEASED-NAME (Type or print) William			First Smith			Middle			Last			2a. DATE OF DEATH Month March Day 8 Year 1969			2b. HOUR 10 A M		
3 SEX Male			4 RACE Negro			5. DATE OF BIRTH April 9, 1912			6. AGE (In years lost birthday) 56 YRS.			IF UNDER 1 YEAR MONTHS 10 DAYS 29			IF UNDER 24 HRS HOURS 10 MIN 30		
7a. BIRTHPLACE (State or foreign country) MD			7b. CITIZEN OF WHAT COUNTRY? US			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH HARFORD								
10. CITY OR TOWN OF DEATH HAVERDALE GRACE			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) HARFORD MEMORIAL HOSP			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Chemical Bnt.								
13a. USUAL RESIDENCE (Where deceased admission) STATE MD			ved, if institution Residence before 13b. COUNTY HARFORD			13c. CITY OR TOWN CHURCHVILLE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER RD 1 Box 567					
14. FATHER'S NAME John Smith			First Smith			Middle			Last			15. MOTHER'S MAIDEN NAME Carrie Cooper			First Cooper		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO 202-05-008			17. INFORMANT Victoria F. Brooks			Address 826 E Street N.E. Washington D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction															6 hrs		
412.2 DUE TO, OR AS A CONSEQUENCE OF Hypertensive Cardiovascular Disease															12 yrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
DUE TO, OR AS A CONSEQUENCE OF (b) Acute gastro-enteritis																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
Acute gastro-enteritis																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from Sept 1957 , to March 8, 1969 , that (I) (we) last saw the deceased alive on MARCH 8, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Ralph Horky			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3/8/69								
22d. PHYSICIAN'S NAME (Type) Dr. Ralph Horky			22e. ADDRESS Churchville MD														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/12/69			23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery			23d. LOCATION (City or Town) (County) (State) Churchville Harford MD								
24. FUNERAL DIRECTOR Elmer E. Bullork			25a. REC'D BY REGISTRAR Harford			25b. REGISTRAR'S SIGNATURE Harford			DATE MAR 12 1969								

03959

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1 DECEASED NAME (Type or print) Roy Christopher		First Middle Last		2a. DATE OF DEATH Month Day Year March 17, 1969		2b. HOJR 129 M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH March 16, 1969		6. AGE (In years last birthday) YRS MONTHS DAYS 23 55	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10 CITY OR TOWN OF DEATH Havre de Grace		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (where deceased lived if institution Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY, TOWNS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME Joseph R		First Middle Last		15 MOTHER'S MAIDEN NAME Elizabeth A. Brown		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO N/A		17 INFORMANT Joseph Roy Strong III, Aberdeen, Md.			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous - 26 weeks gestation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Spontaneous Rupture of membranes</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 16, 1969, to March 17, 1969, that (I) (we) last saw the deceased alive on March 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Frederick Hatem, M.D.				22c. DATE SIGNED 3/17/69		22d. PHYSICIAN'S NAME (Type) Frederick Hatem, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 19 Mar. 69		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Aberdeen, (Harford Co.) Md.	
24 FUNERAL DIRECTOR Tarring Funerals Home, Aberdeen, Md. 21001				25a. REC'D BY REG STRA DATE Mar 19 1969		25b. REGISTRAR'S SIGNATURE	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and on any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH	
GEORGE ARCHER THOMPSON								<input checked="" type="checkbox"/> Month Day Year <input type="checkbox"/> ESTI MATED Mar. 31, 1969	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR		7 UNDER 24 HRS		2c DATE PRONOUNCED DEAD	2d HOUR
Male	White	Sept. 3, 1895	73 YRS	MONTHS DAYS		HOURS MIN.		Month Day Year	4p M
7a. BIRTHPLACE (State or foreign)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Whiteford, Md.		USA				Harford			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Whiteford		Pylesville Rd.		Truck Driver		Highways			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Md.		Harford		Whiteford				Pylesville Rd.	
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME	
Harry Thompson								Hannah Hughes	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
No		215-07-8921		Mrs. J. Walter Baldwin		Whiteford, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GSW Left Chest									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. P.M. Mar. 31, 69		Shot self					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No		City or Town		County State	
		Home		Pylesville Rd.		Whiteford		Harford Md	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		M.D.		22b. DATE SIGNED			
<i>Gerald C. Palmer</i>		Gerald C. Palmer		M.D.		Apr. 1, 1969			
						ADDRESS (Street, City, State)			
						Main St., Bel Air, Md.			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Apr. 3, 1969		Highland		Street Harford Md.			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
JOHN H. HARKINS		Delta, Penna.		APR 3 1969		<i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03961

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03955

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Lucy Bertha Turner			2a. DATE OF DEATH Month Day Year March 12 1969			2b. HOUR 6 A.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH March 26, 1883		6 AGE (In years last birthday) 85 YRS	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Harford	
10 CITY OR TOWN OF DEATH Havre de Grace		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Mem. Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13e. STREET AND NUMBER 118 Phila. Rd.	
14. FATHER'S NAME First Middle Last Thomas -- Turner				15. MOTHER'S MAIDEN NAME First Middle Last Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) no		16b. SOCIAL SECURITY NO none		17 INFORMANT Charles E. Fitez, 118 Philadelphia Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Cardiac Decompensation 2-3 months DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. 3-4 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) -							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Malnutrition + Anemia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3-11, 1969, to 3-12, 1969, that (I) (we) last saw the deceased alive on 3-12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward C. Loo, M.D.				22c. DATE SIGNED 3/12/69		22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 14, 1969		23c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Abingdon Harford Md.	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.				25a. REC'D BY REGISTRAR MAR 14 1969		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03962

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03956

1. DECEASED-NAME (Type or print) <u>John Wesley Walker</u>		2a. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>69</u>		2b. HOUR <u>8:30</u> M
3 SEX <u>Male</u>	4 RACE <u>Negro</u>	5 DATE OF BIRTH <u>Sept 2, 1885</u>	6 AGE (In years last birthday) <u>83</u> YRS.	IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>
7a BIRTHPLACE (State or foreign country) <u>Pa</u>	7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <u>Hartford</u> Md.	
10 CITY OR TOWN OF DEATH <u>Hartford</u>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Hartford Memorial Hospital</u>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Retired</u>	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <u>Md</u>	13b COUNTY <u>Cecil</u>	13c CITY OR TOWN <u>Port Deposit</u>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <u>Rt 84 Port Deposit</u>
14 FATHER'S NAME First Middle Last <u>Unknown</u>	15 MOTHER'S MAIDEN NAME First Middle Last <u>Unknown</u>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>	16b SOCIAL SECURITY NO <u>217-07-0854</u>	17 INFORMANT <u>William Montgomery, Port Deposit, Md</u>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY <u>4320</u> IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis, generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No	City or Town County State
22a. I certify that (I) (th s hospital) attended the deceased from <u>3-1, 1969</u> , to <u>3-1, 1969</u> , that (I) (we) lost saw the deceased alive on <u>3-1, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (d not) view the body after death				
22b SIGNATURE <u>Dr. W. Monakic, M.D.</u>		DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED <u>3/2/69</u>
22d PHYSICIAN'S NAME (Type) <u>DAVID W. MONAKIC, M.D.</u>		22e ADDRESS <u>241 N. Union Ave, Hartford, Conn.</u>		
23a BURIAL, CREMATION, REMOVAL, (Specify)	23b DATE <u>3/5/1969</u>	23c NAME OF CEMETERY OR CREMATORY <u>Colesbury Baptist Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>Port Deposit Cecil Md.</u>	
24 FUNERAL DIRECTOR <u>Lee G. Patterson, San Perryville, Md</u>	ADDRESS	25a REC'D BY REGISTRAR <u> </u>	25b REGISTRAR'S SIGNATURE <u>James Judge</u>	DATE <u>MAR 6 1969</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03963

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03957

1. DECEASED NAME (Type or print) Boulah MAE WALL			2a. DATE OF DEATH Month MARCH Day 2 Year 69			2b. HOUR 1 1/2 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 12/28/1901		6. AGE (In years last birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD	
10. CITY OR TOWN OF DEATH HAURE DE GRACE		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Harford Memorial Hosp		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b. COUNTY HARFORD		13c. CITY OR TOWN HAURE DE GRACE		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER 717 Chesapeake Drive		14. FATHER'S NAME First WALTER Middle M. Last GILBERT		15. MOTHER'S MAIDEN NAME First HELOA Middle (NMI) Last CUNHISON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO YES		17. INFORMANT MR George Pensell 704 Chesapeake Dr.		Address HAURE DE GRACE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Transition to Arterio Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2-21, 1969 , to 3-2, 1969 , that (I) (we) last saw the deceased alive on 3-2, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dante U. Monakil, M.D. DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE/SIGNED 3/2/69			
22d. PHYSICIAN'S NAME (Type) DANTE U. MONAKIL, M.D.				22e. ADDRESS 21 N. Union Ave. Harre de Grace, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/6/1969		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAURE DE GRACE HARFORD MD	
24. FUNERAL DIRECTOR Gertrude H. Saw Address Harre de Grace, Md.				25a. REC'D BY REGISTRAR DATE MAR 6 1969		25b. REGISTRAR'S SIGNATURE James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03964 CERTIFICATE OF DEATH 03958											
1. DECEASED-NAME (Type or print) Martha EVA Wildason			2a. DATE OF DEATH Month 3 Day 14 Year 1969			2b. HOUR 5:08 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH 1-10-1884		6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0			
7a. BIRTHPLACE (State or foreign country) Harf. Co., Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Co., Md.					
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizen's Hsg. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife		12b. KIND OF BUSINESS OR INDUSTRY Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1104 Tollgate Rd.		
14. FATHER'S NAME First JAMES HENRY Middle Miller Last Miller			15. MOTHER'S MAIDEN NAME First MARY Middle Ellen Last Baker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 215-54-0561		17. INFORMANT Mrs. William E. Wildason Address 2223, Box 134 Bel Air, Md. 21014						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardiac Decompensation. 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Atrial Fibrillation. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2-11-1969 to 2-14-1969 , that (I) (we) last saw the deceased alive on 2-13-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Santer A. Monakel MD. DEGREE PAUTE W. MONAKEL						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/14/69			
22d. PHYSICIAN'S NAME (Type) PAUTE W. MONAKEL						22e. ADDRESS 211 N. Union Ave. Havre de Grace, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 16, 1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Meth. Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Houston Green, Harf. Co., Md.				
24. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams St. Bel Air, Maryland 21014						25a. REC'D BY REGISTRAR MAR 17 1969		25b. REGISTRAR'S SIGNATURE John H. [Signature]			

1. The first part of the report is a general
description of the project and its objectives.
2. The second part is a detailed description of the
methodology used in the study.
3. The third part is a description of the results
of the study.
4. The fourth part is a discussion of the results
and their implications.
5. The fifth part is a conclusion and a list of
references.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03965

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05505

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Carol Lynn Wise						Month Day Year			11:00 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	Cau	9 February '69	YRS. 1	MONTHS 11	DAYS 11	HOURS	MIN.	Mar. 21 1969			11:00 AM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH					
Maryland		United States		WIDOWED		Harford					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
APG			U.S. Kirk Army Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Harford			APG			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
Emery R. Wise			Esther M. Snurr			No					
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Emery R. Wise, 2741 B. Augusta St., A.P.G.,			Aberdeen, Md.			PART 1. DEATH WAS CAUSED BY:					
						IMMEDIATE CAUSE (a) Probable Strangulation, Marks and Trauma on Neck					
						DUE TO, OR AS A CONSEQUENCE OF					
						(b)					
						DUE TO, OR AS A CONSEQUENCE OF					
						(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				11:00 P.M. 3 21 19 69				Probable strangulation with hosiery			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Home				2741 B Augusta Street, A.P.G., Harford Co., Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
Acting Medical Examiner on Federal Property											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
Thomas Fraher								7 Apr 69			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)			
Thomas Fraher, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			3/26/69			Green Hill			Waynesboro, Franklin Co. Penna.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Kenneth B. Earp						DATE			APR 10 1969		
Tarring Funeral Home, Aberdeen, Maryland									J Charles Judge		

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